Holistic Psychotherapy
30 Old Kings Highway South
Darien, Connecticut 06820
203-655-4854

GOOD FAITH ESTIMATE FOR PRIVATE PAY AND UNINSURED INDIVIDUALS

This is an estimate of the cost of psychotherapy services for the year _____

Please note, additional recommendations may be made as treatment progresses.

Client Name and Date of Birth_____

I expect that my care of you will require continued _____

therapy sessions through the end of the year at _____per session for a total of

_____weeks.

This course of treatment can be more or less depending on the progress we make.

Thank you for entrusting me with your care.

Client or Legal Guardian Signature and Date_____